DELTA DENTAL®

When complete mail to:
Guarantee Of Service Excellence℠ Program
Northeast Delta Dental
P.O. Box 2002
Concord, NH 03302-2002

Guarantee Of Service Excellence℠ Program Refund Request

Date: _____ Group Name: _____

Group Address: _____

City: _____ State: _____ Zip: _____ Group/Sub #: __ __ __ __ - __ __ __ __

Group Representative Requesting Refund: _____

Title of Group Representative: _____ Telephone #: (_ _ _) - _ _ _ - _ _ _ _

Name of Subscriber (if applicable): _____

Name of Dentist (if applicable): _____ Dentist City/Town: _____

Nature of Problem (please check below)

❶ **Smooth Implementation to Northeast Delta Dental**
[ ] Did not successfully meet the criteria for smooth implementation.

❷ **Exceptional Customer Service**
[ ] Did not resolve a telephone inquiry immediately or provide an update within one business day.

❸ **Quick Processing of Claims**
[ ] Less than 90% of a group's accurately completed claim forms processed correctly within 15 days.

❹ **No Inappropriate Billing by Participating Dentists**
[ ] Patient charged for more than the appropriate co-payment at the time of service or for any difference between a participating dentist's submitted fee and Delta Dental's approved amount (attach copy of bill).

❺ **Accurate and Quick Turnaround of Identification Cards**
[ ] Not mailed within 15 calendar days.
[ ] Not accurate.

❻ **Timely Employee Booklets**
[ ] Not mailed within 15 calendar days of request, finalized benefits change, or receipt of signed contract.

❼ **Marketing Service Contacts**
[ ] Group did not receive at least two Marketing service contacts during a contract term.

Briefly describe below the problem and attach appropriate supporting information including names and dates.

_____

_____

_____

_____

_____

_____ Your Initials: _____

Refund checks will be mailed to your group address as specified above.
Thank you for making it possible for us to serve you better.

For Delta Dental Use Only

Check #: _____ Check Date: _____ GL#: 725.7876.01 Code: _____ Guar #: _____
Refund Approved By: _____ Date Approved: _____ Amount Paid: _____
Letter Signed By: _____

Form # GRRF_0107